



February 3, 2010

Dear Colleagues:

The recent institution of midwifery practice law has a respectable history in Idaho with the Idaho Perinatal Project (IPP). The IPP involvement began at least 5 years ago after many of our colleagues throughout the state were reporting an increase in volumes of obstetrical patients presenting to outlying and local hospitals under the care of lay midwives. Our assistance in tracking and evaluating possible solutions followed. These efforts included education and communication with providers and the public and led to communication between the IPP and lay midwives.

At the subsequent IPP winter conference, midwifery practice was a keynote topic of discussion and followed by 2 concurrent years of failed bills in the senate and house, respectively. The medical community cooperated in their opposition to these bills and created much discord between these groups. The goal of both parties was to provide a safer solution for this option in our state. In the third year, with the cooperation of the medical community, the IPP, IMA (Idaho Medical Association), a bill sponsor and lay midwives, a successful bill was passed to law without remarkable in 2009. Many opportunities for education and communication were available during this period. With the legislative assistance from the IMA, and the involved health care providers, statutes were created in the bill that were used to guide the rules by the newly formed midwifery board.

Though much is present in the law that remains unsatisfactory to many in the medical community, it is perceived as improved from a previous absence of safeguards. As an additional measure, a sunset clause is present that will allow the law to expire in 2014, unless reviewed. Trending and follow-up of complications will continue by both parties including the midwifery board. The newly formed midwifery board recently compiled practice rules. The rules were open to public opinion and open discussion and testimony at the senate and house at the 2010 Idaho state legislative session. The rules may be found at: <http://www.ibol.idaho.gov>.

Though it does appear that licensed midwives (LM) are allowed to practice at a level beyond what the American College of Obstetrics and Gynecology (ACOG) suggests, it is expected that these patients will be making an informed decision. Also, it is to be understood that this bill was modeled after the similarly robust laws of the states of Vermont and Wisconsin, with demonstrated success. The text of the law passed in 2009 may be found at <http://www.idahoperinatal.org/news/index.html>. The summary of this provides highlights for the busy practitioner and is simply a very brief review of the law and not intended as a substitution for reading the entire document. A few definitions are included.

Purpose and Intent legislature finds and declares that the practice of midwifery has been a part of the culture and tradition of Idaho since before pioneer days and that for personal, religious and economic reasons some Idaho citizens will choose midwifery care. The purpose of this legislation is to preserve the rights of families to deliver their children in a setting of their choice, to provide additional maternity care options for Idaho's families, to protect the public health, safety, and welfare, and to provide a mechanism to assure quality care.

Licensed midwife (LM) is a person who holds a current license issued by the board, under this chapter to engage in the practice of midwifery.

Practice of midwifery means providing maternity care for women and their newborns during the antepartum, intrapartum, and postpartum periods. The postpartum period for both maternal and newborn care may not exceed six weeks from the date of delivery.

Licensure It is a misdemeanor for any person to assume or use the title or designation LM or any other title, designation, words, letters, abbreviations, sign, card, or device to indicate to the public that such person is licensed to practice midwifery unless licensed.

Misdemeanor applies to any person who engages in the practice of midwifery without a license.

Felony occurs when a person convicted of a second or subsequent offense under this section.

The qualifications for eligibility are defined and require documentation of completion of courses and certification by well-defined standards including certification in CPR and neonatal resuscitation. Submitting an application to renew a license must compile practice data for the 12 months preceding the date of the application. At a minimum, the

information will include number of women, deliveries, transfers, apgar scores, perinatal deaths, and other relevant morbidity. Waivers for grand-mothering in are defined in the text. All others are NOT allowed to practice midwifery; with rare exceptions.

The board of midwifery was created under the Idaho Bureau of Occupational Licenses (IBOL). Five members of the board are each appointed by the governor. Three must be licensed as defined by the law; one is a physician who practices obstetrics. The remaining member of the board is a member of the public. The current members of the advisory board are listed at the IPP website or at the IBOL links above. The responsibilities of the board are to process applications, provide renewals, determine continuing education needs and investigate complaints and disciplinary action when necessary.

The rules as written will allow a LM to administer certain medications and interventions for basic care of obstetric patients such as oxytocin, penicillin for group B streptococcus, and local anesthetics for routine care as well as protocols for their administration. A scope of practice regarding antepartum, intrapartum, postpartum care and newborn care for the first 6 weeks of life would prohibit a LM from providing care for such conditions as placental abnormalities, multiple gestation, infectious diseases, isoimmunization among other illness outlined in the rules. The rules would prohibit a LM from providing care for a woman unless under direct supervision by a licensed physician with certain conditions such as endocrine, cardiovascular, pulmonary, urinary, gastrointestinal diseases among a few. This would include a LM to recommend that a patient see a licensed physician for a history of previous pregnancy complications such as preeclampsia, preterm birth, cesarean, increased BMI and others similar conditions as outlined in the law.

Mandatory and immediate transfer of care is required to a hospital for emergency care for conditions such as fever, vaginal bleeding, meconium, preeclampsia, prematurity, malpresentation, etc. The transfer is to be accompanied by medical records and description of care by the LM. A system of peer review for LM is to be established regarding quality, appropriateness and ethics of midwifery care. The rules adopted by the board may not require a licensed midwife to have a nursing degree, practice under the supervision of a physician, enter into a written agreement with another health care provider, limit the location of practice, permit the use of forceps or vacuum in delivery, grant prescription privilege or abortions.

Prior to initiating care the LM shall obtain informed consent for each patient verifying training, how to obtain copy of rules and job description, instructions for filing complaints, availability of liability insurance, written protocol for emergencies and transfer, descriptions of procedures and benefits and risks of home birth and conditions that may arise. Records shall be maintained for 9 years for each client. Prior to providing care of preexisting conditions that warrant physician care or referral, the LM shall provide written documentation and written notice should be provided that the client is advised to consult with a physician during her pregnancy.

Note that this law will become effective on July 2010. Many practitioners throughout the state will or have been contacted by midwives as a resource for consultative care. Hospitals throughout the state will be contacted with requests for education, communication tools and means to streamline transfers of care. As part of the rules and application process, each provider must establish a transfer of care plan that should prove helpful. The midwifery board is expected to begin receiving and reviewing applications for licensure in March 2010. I would urge you to consult your medical staff offices, maternity unit directors, hospital administrators and hospital legal counsel in advance. The law includes a liability clause left to the interpretation of our respective legal teams.

VICARIOUS LIABILITY No physician, hospital, emergency room personnel, emergency medical technician, or ambulance personnel shall be liable for any injury resulting from an act or omission of a licensed midwife, even if the health care provider has consulted with or accepted a referral from the licensed midwife. A physician who consults with a licensed midwife but who does not examine or treat a client of the midwife shall not be deemed to have created a physician-patient relationship with such client.

The IPP asks for your cooperation and open mind as we approach how we communicate with these new licensed providers in our state. It is our desire that enhanced communication and collaboration may follow and that will ultimately improve outcome and collegiality. The IPP remains open for input and reporting of events under this act similar to the reporting of significant events prior to this law.

Thank you for your attention to this lengthy communication and patience with this matter.

Sincerely,

Clarence W. Blea, MD